

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17063

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17057

1. PLACE OF DEATH COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Charles Mt. Victoria Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN 1b 12-Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial LaPlata Md		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Lee Bailey		4. DATE OF DEATH 12-23-66	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Mt. Victoria Md
13. FATHER'S NAME James Bailey		14. MOTHER'S MAIDEN NAME Florence Lucas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-2004-77	
17. INFORMANT Mrs James Goldsmit-Aunt		Address Mt. Victoria Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries Multiple Extreme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Being Run over By A Tractor & Trailer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Skull-Fracture Ribs, Ruptured Spleen			INTERVAL BETWEEN ONSET AND DEATH 17-Hrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was run over by a tractor & Trailer	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 12-23-66 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, office bldg., etc.) Highway		20f. (City or town) (County) (State) Mt Victoria Md Charles	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James E. Andrews MD		22. DATE SIGNED 12-24-66 Indian Head Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 27, 1966	
23c. NAME OF CEMETERY OR CREMATORY Christ Church		23d. LOCATION (City or Town) (County) (State) Wayside, Charles co., Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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*[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

1 (M)

17064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17058

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wicomico (Rural)</b>		c. LENGTH OF STAY IN 1b <b>(Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>GEOFFREY</b> Middle <b>DAWES</b> Last <b>BAKER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1901) <b>April 9, 1902</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Editor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	
11. BIRTHPLACE (State or foreign country) <b>Lynn Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry M. Baker</b>		14. MOTHER'S MAIDEN NAME <b>Lynette Moore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Lynette Cave</b>		Address <b>North Canton, Mass.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>12/2/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>12/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Archard Funeral Home</b>		25. REC'D BY REGISTRAR <b>Lab Page</b>	
ADDRESS <b>Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>DEC 15 1966</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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17065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17059

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wicomico (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wicomico (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>LYNETTE</b> Middle <b>E.</b> Last <b>BAKER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>66</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>90</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Lynn Mass.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13. FATHER'S NAME <b>Henry Moore</b>		14. MOTHER'S MAIDEN NAME <b>Florence Dawes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>Mr. Lynette E. Cave</b> Address <b>North Eastern Conn.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> 4221 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>12/2/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>12/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or town) (County) (State) <b>Swanton, Me.</b>
24. FUNERAL DIRECTOR <b>Archard Funeral Home, LaPlata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

13059

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FOR STATE  
HEALTH DEPT.

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17066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17060

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River, Benedict</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benedict</u> 08.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Patuxent River</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) First <u>Randall</u> Middle <u>Eugene</u> Last <u>Bland</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1947</u>
9. AGE (In years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Road</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Lawrence Bland</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Marie Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address <u>same as # 2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>929.8</u> IMMEDIATE CAUSE (a) <u>Drowning</u> 12-8-66 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>While ducking, boat broke anchor</u> (c) <u>and he tried to swim to retrieve it</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18). <u>Patuxent R. Duck hunting when boat got loose</u>	
20c. TIME OF INJURY Hour <u>0.00</u> Month <u>12</u> Day <u>8</u> Year <u>1966</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Patuxent R.</u>		20f. (City or town) (County) (State) <u>Benedict Charles</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward J. Edelen M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>12-9-66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-11-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	23d. LOCATION (City or Town) (County) (State) <u>Great Mills, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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17067

## CERTIFICATE OF DEATH

18056

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hospital</u>		d. STREET ADDRESS <u>SE. Rt. 3 La Plata</u>	
3. NAME OF DECEASED (Type or print) <u>KEVEN ALEXANDER CHESLEY</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Aug 66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHARLES Co. MD.</u>	
13. FATHER'S NAME <u>THOMAS O. CHESLEY</u>		14. MOTHER'S MAIDEN NAME <u>JULIA FARMER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JULIA CHESLEY</u>		Address <u>LAPLATA MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> DUE TO (b) <u>Bronchitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 Dec</u> , 19 <u>66</u> , to <u>30 Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>30 Dec</u> , 19 <u>66</u> , and that death occurred at <u>8:10 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur O. Woody</u>		22b. DATE SIGNED <u>30 Dec 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		22d. ADDRESS <u>JARWOOD CLINIC LAPLATA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>12-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>	23d. LOCATION (City or Town) (County) (State) <u>NEW PORT CHARLES MD</u>
24. FUNERAL DIRECTOR <u>Wickhart Inc. LaPlata Md</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11087

CONFIRMATE OF DEATH

18876

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17068

17061

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 4, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dentsville (Dentsville) Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dentsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>WILLIAM ROSS COOLEY</b>				4. DATE OF DEATH <b>12 21 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 13, 1924</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		10. UNDER 1 YEAR Months <b>12</b> Days <b>21</b>		11. UNDER 24 HRS. Hours <b>19</b> Min.		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic- Refrigeration</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William C. Cooley</b>				14. MOTHER'S MAIDEN NAME <b>Maude E. King</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW2</b>				16. SOCIAL SECURITY NO. <b>Unkown</b>			
17. INFORMANT <b>Bettie Cooley, Rt. 3, La Plata, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>919.0</b> IMMEDIATE CAUSE (a) <b>Punctured wound of chest</b> Conditions, if any, which gave rise to immediate cause (b) <b>Handling gun</b> (a), stating the underlying cause last. (c) <b>12 21-66</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gun apparently placed on table &amp; discharged</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10</b> p.m. <b>12-21-66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Residence Dentsville Charles Co</b>		20f. CITY or town (County) (State) <b>La Plata Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. J. Deeken</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. J. Deeken</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 26, 1966</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gardens</b>				22d. LOCATION (City, town, or county) (State) <b>Waldorf, Charles Co., Md.</b>			
23. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>				24. REC'D BY REGISTRAR <b>DEC 23 1966</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 17062

17062

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>				c. LENGTH OF STAY IN 1b <b>88.1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST CHARLES CLINIC</b>				d. STREET ADDRESS <b>P.O. Box 124</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RONALD</b> Middle <b>LEMOIN</b> Last <b>HARMON</b>				4. DATE OF DEATH Month <b>12</b> Day <b>12</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 26, 1909</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROGRAM ANALYST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT</b>		11. BIRTHPLACE (State or foreign country) <b>NEBRASKA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM C. HARMON</b>				14. MOTHER'S MAIDEN NAME <b>JULIA GOODENBERGER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>506-05-1778</b>		17. INFORMANT <b>THELMA HARMON, Box 124, WALDORF, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>ARTERIO SCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> (c) <b>HYPERTENSION</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b> <b>&gt; 2 YEARS</b> <b>&gt; 2 YEARS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AORTIC VALVE DISEASE, PROBABLY ARTERIO SCLEROTIC</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>10/19/63</b> , to <b>DEATH</b> , 19 <b>66</b> , that I last saw the deceased alive on <b>11/23</b> , 19 <b>66</b> , and that death occurred at <b>6 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ST CHARLES CLINIC</b> DATE SIGNED <b>12-12-66</b>							
ACTUAL SIGNATURE <b>Robert W. Merkle, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>ROBERT W. MERKLE</b> <b>WALDORF, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-16-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>WALDORF, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17070

CERTIFICATE OF DEATH

17068

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Madison</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bridgeport</b> <b>69.3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>R.D. #1</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM G. HEFFRON</b>		4. DATE OF DEATH Month <b>12</b> - Day <b>12</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Borden Milk Co.</b>	9. AGE (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Middleton, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>029-85-9182</b>	
17. INFORMANT <b>May Bell Heffron -Wife</b>		Address <b>New York Bridgeport,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toric gangrene left foot</b> DUE TO (b) <b>bleeding septic ulcer</b> DUE TO (c) <b>lobar pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days - 4 mths. 6 mths</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-22</b> , 19 <b>66</b> , to <b>12-12</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-12</b> , 19 <b>66</b> , and that death occurred at <b>Midnight</b> from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. Johnson MD</b>		22b. DATE SIGNED <b>12-13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON MD</b>		22d. ADDRESS <b>LA PLATA, MD. 20646</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/15/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Morningside Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Syracuse, New York</b>
24. FUNERAL DIRECTOR <b>Goddard &amp; Crandall Funeral Home Syracuse</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					17064										
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>IRONSIDES</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RT 1 LAPLATA (RURAL)</b>			d. STREET ADDRESS							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>ARCHIE Lee JOHNSON</b>			First Middle Last		4. DATE OF DEATH <b>12 16 1966</b>		Month Day Year								
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE? 1905</b>		9. AGE (In years last birthday) <b>61</b> yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME CONSTR.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM JOHNSON</b>					14. MOTHER'S MAIDEN NAME <b>ELLEN MASON</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>216-1273256</b>					17. INFORMANT <b>JOHN JOHNSON, LA PLATA, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Occlusion 12-16-66</b> Conditions, if any, which gave rise to immediate cause (b) <b>Ren. Cere. Acc</b> (a), stating the underlying cause last. (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12-16-66</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										DATE SIGNED <b>12-16-66</b>					
ACTUAL SIGNATURE <b>E. J. EDELEN</b>					M.D. <b>E. J. EDELEN, LAPLATA, MD.</b>										
EXAMINER'S NAME (Type)					Address (Street, city, town, or county)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>12-20-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OLD DURHAM Cem.</b>			22d. LOCATION (City, town, or county) (State) <b>IRONSIDES MD.</b>							
23. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Waldorf, Md.</b>					ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 22 1966</b>			24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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FOR STATE  
HEALTH DEPT.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VA</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physician Memorial Hosp.</b>		d. STREET ADDRESS <b>PORT ROYAL 83-3</b>	
3. NAME OF DECEASED (Type or print) First <b>JOYCE</b> Middle <b>ANN</b> Last <b>KAY</b>		4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 8 1942</b>
9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>LINWOOD KAY</b>		14. MOTHER'S MAIDEN NAME <b>GRACIE COLLAWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MAHN Funeral Home, Bowling Green VA.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Struck and run over</b> DUE TO (b) <b>Crushed chest</b> DUE TO (c) <b>Auto accident (passenger)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12-7-66</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck in auto hit by it faster than</b>	
20c. TIME OF INJURY Month, Day, Year <b>11 12 7 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <b>301 Main</b>		20f. (City or town) <b>McClatchy Ches</b> (County) <b>VA</b> (State) <b>VA</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. J. Edelen</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) <b>12-8-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN</b>		23d. LOCATION (City or Town) <b>Bowling Green</b> (County) <b>VA</b> (State) <b>VA</b>	
24. FUNERAL DIRECTOR <b>MAHN Funeral Home, Bowling Green VA.</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Edelen</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COBB ISLAND</b>		d. STREET ADDRESS <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>Samuel</b> Last <b>LANDIS</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Nov 1899</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE M. LANDIS</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Terise Shugrus</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>279-10-683</b>	
17. INFORMANT <b>GEORGE M. LANDIS II</b>		Address <b>923 GRANDIN AVE ROCKVILLE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> DUE TO (b) <b>Myocardial infarction - 2 weeks</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>30 Nov 1966</b> , to <b>2 Dec 1966</b> that (I) (we) last saw the deceased alive on <b>2 Dec 1966</b> , and that death occurred at <b>6:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody</b>		22b. DATE SIGNED <b>2 Dec 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		22d. ADDRESS <b>SARWOOD CLINIC, LAPLATA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>12/6/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Ft. Myer, Va.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>The Mt.aine Co. 2901 14th ST. NW.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If necessary, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

73051

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17074

CERTIFICATE OF DEATH

17067

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb <b>La Plata</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hosp.</b>		d. STREET ADDRESS <b>08.1</b>	
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>E.</b> Last <b>LEY</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardening-Nursery-Flowers</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>England</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY <b>Great Britain</b>	
13. FATHER'S NAME <b>John H. Ley</b>		14. MOTHER'S MAIDEN NAME <b>Louisa King</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unkown</b>	
17. INFORMANT <b>Mrs. Merion McKenna-Neice Phil., Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> , 19 <b>66</b> , to <b>12-24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-24</b> 19 <b>66</b> , and that death occurred at <b>4:15</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. JOHNSON</b>		22b. DATE SIGNED <b>1-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON MD</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 29, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Md.</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>			

13083

STATE OF ALABAMA

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17075

## CERTIFICATE OF DEATH

17068

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL</b>		d. STREET ADDRESS <b>081</b>	
3. NAME OF DECEASED (Type or print) <b>LINDA First "URON" Middle "MAYER" Last</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Sept 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HW</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>85</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel T. Uron</b>		14. MOTHER'S MAIDEN NAME <b>Clara Seltzer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-54-5642-T</b>	
17. INFORMANT <b>Wm. H. Mayer Jr., La Plata, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>CUA</b> DUE TO (b) <b>Hypertension arterio-sclerotic heart disease</b> DUE TO (c) <b>Generalized senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>24 Nov 66</b> , 19 <b>66</b> , to <b>7 Dec</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7 Dec</b> , 19 <b>66</b> and that death occurred at <b>10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody</b>		22b. DATE SIGNED <b>7 Dec 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		22d. ADDRESS <b>La Plata, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-10-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rest Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>La Plata, Charles, Md.</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 12 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17076

CERTIFICATE OF DEATH

17069

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hosp.</b>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>CORA</b> First <b>McDonald</b> Middle <b>McDonald</b> Last		4. DATE OF DEATH <b>Dec 6 19 66</b> Month <b>Dec</b> Day <b>6</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-1900</b> Yrs. <b>65</b>
9. AGE (In years lost (birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>W. VA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>OSCAR</b>	
14. MOTHER'S MAIDEN NAME <b>Sophia STALNAKER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>232-0-6386B</b>		17. INFORMANT <b>MARY PRICE, LA PLATA, MD.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO <b>Gen. Arteriosclerosis</b> (b) <b>331X</b> DUE TO <b>331X</b> (c) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypostatic Pneumonia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> , 19 <b>66</b> to <b>12/6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/6</b> , 19 <b>66</b> , and that death occurred at <b>7:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Arturo M. Monteiro</b>		22b. DATE SIGNED <b>12/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arturo M. Monteiro</b>		22d. ADDRESS <b>P.O. Box 807 La Plata, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-8-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PARSONS, TUCKER, W. VA.</b>	
24. FUNERAL DIRECTOR <b>Greenlief Funeral Home, Parsons, W. Va.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>DEC 12 1966</b>			

17008

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17077

CERTIFICATE OF DEATH

17070

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSP.</b>		d. STREET ADDRESS <b>HUGHESVILLE</b>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>MAE</b> Last <b>Montgomery</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 25, 1907</b>
9. AGE (In years last birthday) yrs. <b>59</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CHARLES, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BASSFORD</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA G. MONTGOMERY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PAUL B. MONTGOMERY</b>		Address <b>HUGHESVILLE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6 APRIL</b> , 19 <b>65</b> , to <b>16 DEC</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>16 DEC</b> , 19 <b>66</b> , and that death occurred at <b>10:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. G. Barry Mason MD</b>		22b. DATE SIGNED <b>18 DEC 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. G. Barry Mason</b>		22d. ADDRESS <b>Jarwood Clinic, La Plata, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-21-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST MARYS Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>BRYANTOWN, MD.</b>	
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WILDORE, MD</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



13070

EXHIBIT OF THE

13070

CHARLES  
MONTGOMERY  
THE

Physician's Memorial

MAE

June 22, 1907

HOUSEWORK DOMESTIC CHARLES, Maryland U.S.A  
WILLIAM BASSFORD  
MARTHA G. MONTGOMERY  
PAUL B. MONTGOMERY, MD.  
NO

19-07-07 ST. MARKS GEN. PRINTER, MD  
Hunt Creek Home, Bassford, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

17078

CERTIFICATE OF DEATH

17071

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WALDORF</u>		c. LENGTH OF STAY IN 1b <u>18.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>ERIC</u> Last <u>PETZOLD</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>27</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRON WORKS</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LINDENAU, GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT PETZOLD</u>		14. MOTHER'S MAIDEN NAME <u>ALVINE WENZELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>579-09-7144</u>	
17. INFORMANT <u>WILLY PETZOLD, WALDORF, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANGINA</u> (c) <u>2 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>12-27</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>12-23</u> , 19 <u>66</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>F.M. Johnson</u>		22b. DATE SIGNED <u>12-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.M. JOHNSON M.D.</u>		22d. ADDRESS <u>LA PLATA, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-30-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CAKLAND CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WALDORF, CHARLES, MD.</u>	
24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1503 F

7284



FOR STATE  
HEALTH DEPT.

17079

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17072

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VA</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN 1b <u>83-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PHYSICIANS MEMORIAL HOSP</u>		d. STREET ADDRESS <u>PORT ROYAL</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID BERNARD POWERS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27 1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) <u>38</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES T. POWERS</u>		14. MOTHER'S MAIDEN NAME <u>EDITH MOULD MAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MANU FUNERAL HOME, BOWLING GREEN</u>		Address <u>VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>816.1</u> IMMEDIATE CAUSE (a) <u>C.V.A. - thrombotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>passenger in auto</u> (c) <u>12/11/66</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12/11/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>hit by truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:00</u> a.m. <u>12</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>301 Preston Street</u>		20f. (City or town) <u>Port Royal</u> (County) <u>Caroline</u> (State) <u>VA</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. STANLEY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>12-11-66</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-11-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>		23d. LOCATION (City or Town) (County) (State) <u>PORT ROYAL, CAROLINE, VA</u>	
24. FUNERAL DIRECTOR <u>MANU FUNERAL HOME, BOWLING GREEN</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
Address <u>VA</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>DEC 12 1966</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

13035

13035

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17080**

**CERTIFICATE OF DEATH**

**17073**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
*By Deputy Medical Examiner Dr. James De-James - J. Barry Mason, M.D. - J. Barry Mason, M.D.*

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN 1b <u>12 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherley Forest</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PHYSICIANS MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>3510 56th Place</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOHN</u> First <u>Louis</u> Middle <u>Scheibach</u> Last				<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21, 1896</u>		9. AGE (In years last birthday) yrs. <u>70</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipman U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>			
13. FATHER'S NAME <u>Frederick Scheibach</u>				14. MOTHER'S MAIDEN NAME <u>Christine Worn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT Address <u>Grace J. Scheibach Cherley Forest Md</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO (b) <u>Carotid thrombosis, right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerotic Vascular Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>Years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3 Dec</u> , 19 <u>66</u> , to <u>4 Dec</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>4 Dec</u> , 19 <u>66</u> , and that death occurred at <u>3:50</u> AM, from causes and on the date stated above.					
22a. SIGNATURE <u>J. Barry Mason</u>		22b. DATE SIGNED <u>4 Dec 66</u>		22c. PHYSICIAN'S NAME (Type) <u>La Plata, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>					
25a. REC'D BY REGISTRAR DATE <u>DEC 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17074

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy</b>		c. LENGTH OF STAY IN 1b <b>Nanjemoy</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>281</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IOIA THOMPSON</b>		4. DATE OF DEATH Month Day Year <b>December 21 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1880</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Charles Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Clarinda Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Irene Dunbar, Nanjemoy, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12/22/66</b>	
ACTUAL SIGNATURE <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chicamuxen M.S.</b>		23d. LOCATION (City or Town) (County) (State) <b>Chicamuxen, Charles, Md.</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

17034

17034



17082

## CERTIFICATE OF DEATH

17075

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HUGHESVILLE</u>				c. LENGTH OF STAY IN TB			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HUGHESVILLE</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NICHOLAS AUGUSTINE TOLLA</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>28</u> - Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAV.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-6-1897</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA, HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS TOLLA</u>				14. MOTHER'S MAIDEN NAME <u>JULIA ABFALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-36-6713</u>		17. INFORMANT Address <u>MARY CONNICK, AQUASCO, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebrovascular infarction</u> DUE TO (c) <u>Sudden</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R DE VILLARREAL</u>				22d. ADDRESS <u>St Leonard Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>BRYANTOWN, MD.</u>	
24. FUNERAL DIRECTOR <u>Shirley Funeral Home, Waldorf, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17083

TESTIMONY OF DEATH

17083

DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.  
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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17083											
17076											
1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rison</u> c. LENGTH OF STAY IN b. <u>1 Month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.O. Address Rt 1 Box 407 Indian Head Md</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u> d. STREET ADDRESS <u>081</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Drury</u> Last <u>Wood</u>			4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>January 22 1896</u>			9. AGE (In years last birthday) <u>90 yrs.</u>			10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's County, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Joseph Levi Drury</u>			14. MOTHER'S MAIDEN NAME <u>Mary Jane Hill</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-07-0938</u>			17. INFORMANT <u>Mrs. Julia Delozier, Rt. 1 Box 407, Indian Head Md</u>			Address <u>Indian Head Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Acute Myocardial Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertensive Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>20 yrs.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 1966</u> to <u>12/3 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 19 1966</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank A. Susan</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/3/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>						22d. ADDRESS <u>Rt. 1 Box 50, Indian Head Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>12-3-66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ST CHARLES CEM</u>			23d. LOCATION (City, town or county) (State) <u>INDIAN HEAD, MD</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME, WA-L DORF, MD</u>						25a. REC'D BY REGISTRAR <u>DEC 7 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		

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